MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF FOOD AND DRUGS
305 SOUTH STREET, JAMAICA PLAIN, MA 02130
(617) 983-6700

AMBULANCE SERVICE – CONTROLLED SUBSTANCE REGISTRATION APPLICATION
(In accordance with regulations of the Department of Public Health at 105 CMR 700.003)

APPLICATION TYPE:
☐ **NEW** ☐ **RENEWAL** ☐ **CHANGE IN STATUS**

1. **AMBULANCE CLASSIFICATION (CHECK WHERE APPLICABLE)**
   ☐ Paramedic: CII, IV, VI* ONLY ☐ Intermediate: CVI* ONLY ☐ Basic: Epinephrine ONLY
   * Schedule CVI are all prescription drugs not listed in Federal Schedules II – V.
2. **NAME OF AMBULANCE SERVICE:** _____
3. **LOCATION OF AMBULANCE:** _____
   No. and Street

   _____
   City State Zip

   A separate application for registration is required for each location.
4. **CORPORATE ADDRESS:** _____
   No. and Street City State Zip
5. **TELEPHONE NUMBER:** _____
   (Area Code)
6. **HOSPITAL PHARMACY SUPPLYING EMERGENCY MEDICATION:**
   Name: _____
   Address: _____
   No. and Street City State Zip
7. **TOTAL NUMBER OF EMTs AT THIS LOCATION:** _____

	Number
Basic	_____
Intermediate	_____
Paramedic	_____

8. **MASS. CONTROLLED SUBSTANCES REGISTRATION NUMBER (IF APPLICABLE)**_____
9. **LICENSE NUMBER:** _____
10. **Please attach a list of all controlled substances in Schedules II, IV and VI that will be maintained by the ambulance service. Include the name, strength and quantity that will be maintained on the ambulance for each of these controlled substances.**

11. Describe the manner in which all controlled substances will be secured:

_____

_____

_____

12. Describe how controlled substances will be replenished and how often:

_____

_____

_____

13. Has the applicant been convicted of any violation of state or federal law relating to the manufacture, distribution or dispensing of controlled substances?

☐ **Yes** ☐ **No**

14. Has any previous registration held by the applicant under any name or corporate or legal entity been surrendered, revoked, suspended, denied or is such action pending?

☐ **Yes** ☐ **No**

If yes, in which state(s)? _____

15. Are you currently authorized to manufacture, distribute, dispense, prescribe, possess or otherwise handle controlled substances in another state or jurisdiction in which you are operating?

☐ **Yes** ☐ **No**

- **If yes for questions 14 – 15, attach letter setting forth circumstances of such action.**

16. Please submit a Registration fee of $50.00 for each Registration application, payable to the Commonwealth of Massachusetts.

I hereby certify that the information on this application is true to the best of my knowledge and that I will comply with the laws of the Commonwealth of Massachusetts and all rules and regulations promulgated by the Department of Public Health. I also certify, pursuant to M. G. L. c.62C, s.49A, that I have to the best of my knowledge and belief filed all state returns and paid all state taxes required under the law.

Signed under the pains and penalties of perjury

Signature of authorized individual: _____ Date: _____

Print Name: _____ Title: _____

_____

(FOR OFFICE USE ONLY)

Report read and reviewed by: _____

Date: _____